



MEDI-SPA APPLICATION

The Applicant represents that the statements and facts are true and no material facts have been suppressed or misstated. If a policy is issued, this Application will become part of the policy as if physically attached. Therefore, it is mandatory that all questions be answered completely. Completion of this Application does not bind coverage.

Instructions:

- 1) Please type or print clearly.
2) Answer ALL questions completely, leaving no blanks (use "N/A" if Not Appropriate).
3) If you need more space for your responses, continue on a separate sheet with letterhead and indicate question number.

INCLUDE THE FOLLOWING AND CHECK THE BOX IF SUBMITTED:

- LOSS HISTORY - Submit company produced 5 year loss history for Professional Liability and General Liability with clearly marked valuation date with breakdowns of incurred losses...
Copies of all marketing materials/brochures.
Current financial statements (audited if available).
Copies of most recent inspection reports within the past three years.
Copy of Informed Consent. Copy provided? Yes No

GENERAL/OVERVIEW INFORMATION

Applicant's Name: _____

Business Address: _____
Street City State Zip

Mailing Address: _____

Website: _____

Date Business Established: _____ If start-up then check the box: Yes (start-up)

Requested effective date: _____ Retroactive date: _____

Current Form Of Insurance: Professional Liability: Claims-made Occurrence
Commercial General Liability: Claims-made Occurrence

Applicant is a:

- Corporation Partnership
Partnership Association Sole Proprietorship
Joint Venture Physician Owned
Other (Please Explain) _____

Applicant operates: For Profit Not for Profit

Franchise Operations: Company Owned # of Locations: Franchised # of Locations:

Limits of Liability - Primary*

- \$500,000/\$1,500,000 \$1,000,000/\$3,000,000 Other

*Professional Liability and General Liability Limits must be the same, but apply separately.

Deductible (applies separately to Professional Liability and General Liability)

- \$5,000 \$10,000 \$25,000 \$50,000 Other

Limits of Liability - Excess Coverage Requested Yes No

- \$1,000,000/\$1,000,000 \$3,000,000/\$3,000,000 Other

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Nurse Practitioners				
Medical Assistants				
Other (define)				
Other (define)				
Other (define)				

12) For those health care professionals that are considered Independent Contractors:

(a) Do they carry their own Professional Liability coverage? Yes No

(b) If yes, list the minimum limits required: _____

(c) Do you request proof of coverage for Independent Contractors? Yes No

RISK MANAGEMENT

13) Has any outside organization conducted an inspection of your facility in the past 3 years? Yes No

If yes, please indicate the name of the organization and the type of inspection: _____

14) Is this facility licensed by the state? Yes No If yes, list the type of licensing and list the state(s). _____

15) Do any of the employees require licensing by the state? Yes No If yes, list the employee name, type of licensing and the state(s). _____

16) Has the applicant's license or certification ever been investigated, limited, revoked, suspended, refused, cancelled or voluntarily surrendered by or to any state/federal licensing board or regulatory agency? Yes No If yes, give details. _____

17) List other accreditation(s), if any: _____

18) List all associations that you are a member of: _____

19) Does your facility have a formalized Risk Management Program? Yes No

20) Who coordinates your Risk Management Program?

Name: _____

Title: _____ Phone Number: _____

21) Is parental consent obtained for all minors treated at your facilities? Yes No

22) Does the Applicant take before and after photographs of every patient? Yes No If no, give details. _____

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23) Do you have any contractual agreements with independent contractors/providers to provide services at your facility?

Yes No If yes, give details and provide a copy of a sample contract. _____

Are certificates of insurance obtained from all contracted providers? Yes No

24) Please indicate all of the hiring/screening procedures used for professionals and others who provide services at your facility:

- Check of educational background, or residency program, when applicable.
- Check of previous employers In writing By telephone
- Check of personal references In writing By telephone
- Check on hospital privileges for physicians, oral surgeons and dentists.

How often do you update your list of specific privileges? _____

- Verify any pending license suspensions or revocations, or any pending disciplinary actions by other facilities.
- Require information on any professional liability or work-related claim that has previously been made against any individual.

25) Does your facility have written job descriptions? Yes No

COMMERCIAL GENERAL LIABILITY INFORMATION (Complete This Section If Requesting GL Coverage)

26) Please provide physical plant information as requested (use additional sheet if necessary):

Address/Occupancy	Square Footage	Age	Type of Construction	# Floors	Type of Fire Protection*

* Fire Protection Key: AS = Automation Sprinkler, H = Heat Detector, S = Smoke Detector, A = Automatic Alarm

27) Please indicate any additional insureds to be included under your facility's General Liability Coverage, including an explanation of their interest.

Name	Address	Interest

28) Was the facility designed for patients to stay overnight? Yes No

29) Does the applicant own or lease equipment? Own Lease

30) Who is responsible for the inspection and maintenance of the equipment? _____

31) Are policies/procedures established to respond to/address patient medical emergencies while at the facility? Yes No

32) What is the construction? _____ Fire Protection Class? _____ Number of Stories? _____



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- 33) Are the electrical, heating and plumbing systems up to code and regularly inspected? Yes No
 If yes, then inspected by whom and what date? _____
 Is the building completely sprinklered? Yes No
 If partially sprinklered, identify those areas that are sprinklered. _____
- 34) Are the fire alarms connected to a local fire station? Yes No
 If yes, what was the date of the last fire alarm inspection? _____

HISTORICAL CARRIER INFORMATION

35) Please provide past policy information as requested. List all Primary Professional Liability and Commercial General Liability policies and Excess policies for each of the past five years. Begin with the current policies on the top line. If Claims Made, give retroactive date:

PRIMARY	Insurer	Policy Period	Premium	Limits	Attachment	CM (w/ Retro) Or Occurrence
<input type="checkbox"/> Professional Liability <input type="checkbox"/> Commercial GL						
<input type="checkbox"/> Excess						
<input type="checkbox"/> Professional Liability <input type="checkbox"/> Commercial GL						
<input type="checkbox"/> Excess						
<input type="checkbox"/> Professional Liability <input type="checkbox"/> Commercial GL						
<input type="checkbox"/> Excess						
<input type="checkbox"/> Professional Liability <input type="checkbox"/> Commercial GL						
<input type="checkbox"/> Excess						
<input type="checkbox"/> Professional Liability <input type="checkbox"/> Commercial GL						
<input type="checkbox"/> Excess						

36) Has the applicant ever had any insurance company decline, cancel, rescind or non-renew Professional Liability coverage? Yes No If provide details. _____

LOSS HISTORY

37) Summary of 5 Year Loss History - Please provide claims history as requested:

Year	# Open	Total Paid	# Closed	Total Paid	Total # of Claims	Total \$ Paid Expense	Total \$ Paid Indemnity	Total \$ Paid

38) If no claims have been reported to you, then initial here: _____



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- 39) Large Loss Description – On a separate sheet of paper list any liability claims or suits made or brought against your facility during the past five years for amounts incurred greater than \$50,000. If no claims or suits greater than \$50,000 then check the box: Submitted on Separate Sheet of Paper
 None Greater than \$50,000
- 40) Are you aware of any circumstance, accident or loss (occurring after the retroactive date) that has not yet been reported but which may result in a claim? Yes No If yes, give dates, allegations and disposition of each claim or suit in the comments section. _____

- 41) Give the valuation date: _____

OTHER

- 42) Does the applicant offer day care services? Yes No

THE UNDERSIGNED DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE UNDERSIGNED AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, HE/SHE (UNDERSIGNED) WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS, AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE PART OF THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND THIS APPLICATION WILL BE ATTACHED TO AND BECOME PART OF THE POLICY.

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE COMPANY IN CONJUNCTION WITH THIS APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THE APPLICATION AND MADE A PART HEREOF.

THIS APPLICATION MUST BE SIGNED BY AN OFFICER OR PRINCIPAL OF THE APPLICANT.

Name of Applicant: _____

Title: _____

Signature: _____

Date: _____

Producer Name: _____

Address: _____

Telephone: _____

Fax: _____